Model predicts who benefits from carotid endarterectomy

Zosia Kmietowicz, *London*

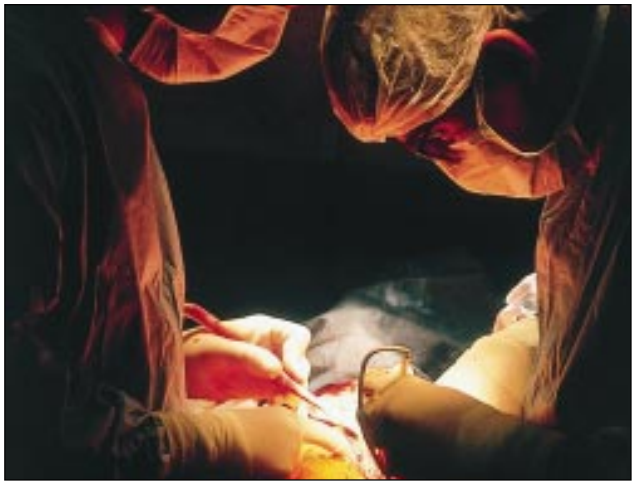
A risk modelling study has been developed to identify which patients stand to benefit most from carotid endarterectomy.

Evidence from large trials on the use of carotid surgery has previously shown that most patients who undergo carotid endarterectomy to reduce their risk of stroke have the operation unnecessarily. Although the procedure lowers the risk of stroke by 50% in the three years after the operation, only 20% of these patients would have had a major stroke if their treatment had been confined to drugs alone.

Researchers from Oxford and Edinburgh have now developed a prognostic scoring system from data on patients from the European carotid surgery trial to identify which patients would most benefit from surgery. The model incorporates seven independent prognostic factors such as past events, degree of stenosis, plaque surface irregularity, raised blood pressure, and sex (women are less likely to benefit from surgery than men).

The analysis showed that endarterectomy was beneficial in only 16% of patients with 70-99% stenosis—the group normally operated on. The operation was judged as being potentially harmful in patients with scores of one or less on the prognostic scale. Among those with a score of four or more, endarterectomy reduced the risk of major stroke or death by 33% over the next five years (*Lancet* 1999;353:2105-10).

"The findings have two implications," suggested Peter Rothwell, senior lecturer in neurology at the University of Oxford, who was one of the authors of the paper. "They can be used to help restrict the use of endarterectomy to those patients most likely to benefit and show that the principle of risk factor modelling could be applied to the results of many other clinical trials to target treatment at those who will benefit." □



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Carotid endarterectomy: model can predict who benefits

WHO's cancer chief resigns

Phyllida Brown, *London*

The chief of the World Health Organisation's cancer programme has resigned over disagreements about the way the UN agency is tackling the growing global burden of non-communicable diseases. Karol Sikora, a clinical oncologist at the Hammersmith Hospital, London, believes that a restructuring of work on non-communicable diseases at the WHO's Geneva headquarters will create a top heavy bureaucracy and weaken the credibility of the agency's advice to countries. The WHO, however, insists that the changes will help member states.

Professor Sikora joined the WHO in autumn 1997. At the time, the cancer programme was based in Lyons at the International Agency for Research on Cancer, and few at the WHO saw cancer as a priority. But with populations ageing worldwide, the prevalence of cancer is rising. Professor Sikora's team produced practical advice for cash strapped governments, such as updated recommendations on which cancer drugs to use.

Now the agency has decided to organise its non-communicable disease activities not primarily by specific diseases, such as cancers and cardiovascular disease, but under three "functional" programmes—prevention, surveillance, and disease management—each with a director under an overall director of all three programmes. Professor Sikora believes that staff will now waste time answering to three bosses instead of one.

Ala Alwan, director of non-communicable disease prevention in Geneva, says that the reorganisation of the work on non-communicable disease will improve coordination and enable hard pressed health services to work more efficiently. The move reflects the WHO's recognition of the importance of non-communicable diseases, he says. Many prevention strategies are shared between diseases, he says—for example, quitting smoking can reduce the risk of both heart disease and cancer.

Professor Sikora believes that a functional approach is valid for infectious diseases but inappropriate for cancer, where the explosion of molecular biology is likely to bring dramatic changes to treatment in rich countries in the next decade. Poorer countries will be under pressure to use high tech approaches too, but, he argues, governments are more likely to be convinced of the validity of more cost effective tools, such as tobacco control, if the advice comes from disease specific experts rather than bureaucrats. Dr Alwan, meanwhile, says that no expertise will be lost as teams for each specific disease will be retained. □

Bristol inquiry reveals that inspections were inadequate

Clare Dyer, *legal correspondent, BMJ*

A committee from the Royal College of Surgeons of England which visited the Bristol Royal Infirmary in July 1994 gave it a "glowing report," the public inquiry into children's heart surgery at the hospital heard last week.

Eleanor Grey, junior counsel to the inquiry, said that the report of the college's specialist advisory committee for cardiothoracic surgery, one of the accreditation committees for higher surgical training, might appear to an outsider as "a dog that did not bark." A few weeks before the visit four out of six consultant anaesthetists had signed a letter to the clinical director of anaesthesia setting out concerns about arterial switch operations for babies with congenital heart anomalies and asking for a review of the switch programme.

Miss Grey asked Barry Jackson, who became president of the Royal College of Surgeons in 1998, what this said about the efficacy of the scrutiny process. He replied: "I would agree that from the outside there seems to be a major anomaly." He "could only surmise" that no anaesthetists were interviewed by the committee, but only surgeons and trainees.

In May 1994 the college's hospital recognition committee, which monitors basic surgical training, visited the Bristol Royal Infirmary, said Miss Grey. The report stated that the intensive care unit was adjacent to the theatre when, in reality, patients had to be taken to another floor. Mr Jackson said that he would have thought this indicated "a rather slipshod approach" had he not known one of the two inspectors and known him to be a "very thorough, conscientious individual." He thought it might be a "typographical error."

Miss Grey said the form used for the inspection asked whether there was any form of audit. The answer was simply "yes, monthly." An outsider might ask whether that was an adequate assessment, she said. □